



1-280

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(800) 6760462 (760) 9497707 FAX (760) 948-1916

07/14/2011 DALLEN 00000006 6381787

01 FC:1599

2430.00 OP

To whom it may concern:

We are considered a micro-small business and woman owned. I have been a neonatal specialty nurse and started this business about 20 years ago. I am filling petitions to reinstate on the following patents and all the documents and letters and evidence for the reasons for unavoidable delay of payment will be the same for all three: *Please accept one copy for all 3. It is a large # of pages.*

Photo Therapy Mask <i>Lee AKA Rogone</i>	"Bili-Bonnet" Dated: March 25, 1997	Appl. No.: 07826096 Exp: 2009	Patent No.: 5613502 Total Fees: \$ 2755.00
Thermal Humidity Barrier <i>Rogone</i>	"Climate Cover" Dated: April 3, 2001	Appl. No.: 09053346 Exp: 2005	Patent No.: 6210320 Total Fees: \$ 2430.00
Infant positioning device <i>Rogone</i>	"Preemie Nest" Dated: May 7, 2002	Appl. No.: 09500736 Exp: 2006	Patent No.: 6381787 Total Fees: \$ 2430.00

I wear many caps in my business and am only an expert when it comes to care of the babies, my husband a respiratory therapist and PA is responsible for the sales and distributors both domestic and abroad and my COO Kenneth S. Croteau RRT who handled many of our business affairs was trying to ensure that our fast growing business was keeping up with all FDA and international requirements for good practice as well as trying to ascertain that all aspects of the business were following all required guidelines and I pick up all financials and the patents and everything else that is not covered and that constitutes our entire administrative staff.

The attorney of record Mr. Lopez who I hired right out of law school joined a firm and handled these utility patents but neglected to inform me of the patent maintenance fees that were due at 3½, 7½ and 11½ years. He then moved to a different firm and we transferred all our business to the new firm but no one contacted us regarding the maintenance fees. I realize now that it was my responsibility and that fees are overdue and have expired. Besides the attorneys neglect there has been a series of terrible and overwhelming occurrences that have plagued our very small company. I fell at the first of the year 2005 and injured my back. Then in horrible pain I began an ordeal of doctors, pain medication, referrals, appointments and a botched surgery in Aug. of 2005. This surgery caused my back to collapse and I shrunk 3 inches in height and the pain was unbearable. I could hardly stand. Again I began another ordeal of, fighting with the HMO, finding a different doctor, and finally, a surgery at Cedars Sinai in Dec. of 2007, to rebuild my back. But, after the surgery and after all the trauma to my spine, my left leg was paralyzed with nerve damage and



MS CC

**PETITION TO ACCEPT UNAVOIDABLY DELAYED PAYMENT OF
MAINTENANCE FEE IN AN EXPIRED PATENT (37 CFR 1.378(b))**

Docket Number (Optional)

Mail to: Mail Stop Petition
Commissioner for Patents
P.O. Box 1450
Alexandria VA 22313-1450
Fax: (571) 273-8300

NOTE: If information or assistance is needed in completing this form, please contact Petitions Information at (571) 272-3282.

Patent Number: 6381787

Application Number: 09500736

Issue Date: MAY 7, 2002

Filing Date: FEB. 9, 2000

CAUTION: Maintenance fee (and surcharge, if any) payment must correctly identify: (1) the patent number (or reissue patent number, if a reissue) and (2) the application number of the actual U.S. application (or reissue application) leading to issuance of that patent to ensure the fee(s) is/are associated with the correct patent. 37 CFR 1.366(c) and (d).

Also complete the following information, if applicable:

The above-identified patent:

☐ is a reissue of original Patent No. _____ original issue date _____;
original application number _____
original filing date _____

☐ resulted from the entry into the U.S. under 35 U.S.C. 371 of international application
_____ filed on _____

CERTIFICATE OF MAILING OR TRANSMISSION (37 CFR 1.8(a))

I hereby certify that this paper, along with any paper referred to as being attached or enclosed) is

(1) being deposited with the United States Postal Service on the date shown below with sufficient postage as first class mail in an envelope addressed to Mail Stop Petition, Commissioner for Patents, P.O. Box 1450, Alexandria, VA 22313-1450 OR

(2) transmitted by facsimile on the date shown below to the United States Patent and Trademark Office at (571) 273-8300.

7/7/11
Date

M Sharon Rogore
Signature

M Sharon Rogore
Typed or printed name of person signing Certificate

Under the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number.

1. SMALL ENTITY

☒ Patentee claims, or has previously claimed, small entity status. See 37 CFR 1.27

2. LOSS OF ENTITLEMENT TO SMALL ENTITY STATUS

☐ Patentee is no longer entitled to small entity status. See 37 CFR 1.27(g)

3. MAINTENANCE FEE (37 CFR 1.20(e)-(g))

The appropriate maintenance fee must be submitted with this petition, unless it was paid earlier.

NOT Small Entity			Small Entity		
Amount	Fee	(Code)	Amount	Fee	(Code)
<input type="checkbox"/> \$ _____	3 ½ yr fee	(1551)	<input type="checkbox"/> \$ <u>490</u>	3 ½ yr fee	(2551)
<input type="checkbox"/> \$ _____	7 ½ yr fee	(1552)	<input type="checkbox"/> \$ <u>1240</u>	7 ½ yr fee	(2552)
<input type="checkbox"/> \$ _____	11 ½ yr fee	(1553)	<input type="checkbox"/> \$ <u>1730.00</u>	11 ½ yr fee	(2553)

MAINTENANCE FEE BEING SUBMITTED \$ 1730.00

4. SURCHARGE

The surcharge required by 37 CFR 1.20(i)(1) of \$ 700.00 (Fee Code 1557) must be paid as a condition of accepting unavoidably delayed payment of the maintenance fee.

SURCHARGE FEE BEING SUBMITTED \$ 700.00

5. MANNER OF PAYMENT

☒ Enclosed is a check for the sum of \$ 2430.00

☐ Please charge Deposit Account No. _____ the sum of \$ _____

☒ Payment by credit card. Form PTO-2038 is attached.

6. AUTHORIZATION TO CHARGE ANY FEE DEFICIENCY

☐ The Director is hereby authorized to charge any maintenance fee, surcharge or petition fee deficiency to Deposit Account No. _____

7. OVERPAYMENT

As to any overpayment made, please

☐ Credit to Deposit Account No. _____

OR

☒ Send refund check

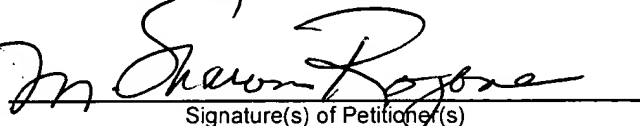
WARNING:

Petitioner/applicant is cautioned to avoid submitting personal information in documents filed in a patent application that may contribute to identity theft. Personal information such as social security numbers, bank account numbers, or credit card numbers (other than a check or credit card authorization form PTO-2038 submitted for payment purposes) is never required by the USPTO to support a petition or an application. If this type of personal information is included in documents submitted to the USPTO, petitioners/applicants should consider redacting such personal information from the documents before submitting them to the USPTO. Petitioner/applicant is advised that the record of a patent application is available to the public after publication of the application (unless a non-publication request in compliance with 37 CFR 1.213(a) is made in the application) or issuance of a patent. Furthermore, the record from an abandoned application may also be available to the public if the application is referenced in a published application or an issued patent (see 37 CFR 1.14). Checks and credit card authorization forms PTO-2038 submitted for payment purposes are not retained in the application file and therefore are not publicly available.

8. SHOWING

The enclosed statement will show that the delay in timely payment of the maintenance fee was unavoidable since reasonable care was taken to ensure that the maintenance fee would be paid timely and that this petition is being filed promptly after the patentee was notified of, or otherwise became aware of, the expiration of the patent. The statement must enumerate the steps taken to ensure timely payment of the maintenance fee, the date and the manner in which the patentee became aware of the expiration of the patent, and the steps taken to file the petition promptly.

9. PETITIONER(S) REQUESTS THAT THE DELAYED PAYMENT OF THE MAINTENANCE FEE BE ACCEPTED AND THE PATENT REINSTATED.


Signature(s) of Petitioner(s)

7/7/11
Date

M SHARON ROGONE (AKA Mary S. Rogone)

Typed or printed name(s)

Registration Number, if applicable

14043 CHOCO RD

Address

760-220-2141

Telephone Number

APPLE VALLEY, CA 92307 usa

Address

ENCLOSURES:

- ☒ Maintenance Fee Payment
☒ Statement why maintenance fee was not paid timely
☒ Surcharge under 37 CFR 1.20(i)(1) (fee for filing the maintenance fee petition)
☒ Other:

MEDICAL RECORDS, DEATH CERTIFICATES, LETTER FROM MD

Under the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number.

37 CFR 1.378(d) states: "Any petition under this section must be signed by an attorney or agent registered to practice before the Patent and Trademark Office, or by the patentee, the assignee, or other party in interest."

M. Sharon Rogone
Signature

7/7/4
Date

M. Sharon Rogone
Type or printed name

Registration Number, if applicable

STATEMENT

(In the space below, please provide the showing of unavoidable delay recited in paragraph 8 above.)

See letter, death certificates, medical records attached

See attached letters and documents--the same one for all 3 patents

(Please attach additional sheets if additional space is needed)

STATE OF CALIFORNIA
CERTIFICATION OF VITAL RECORD

COUNTY of SAN BERNARDINO

DEPARTMENT OF PUBLIC HEALTH

351 N. MT. VIEW AVENUE, SAN BERNARDINO, CALIFORNIA 92415-0010

CERTIFICATE OF DEATH

3201036011290

*My Business Partner
12/06/2010*

STATE FILE NUMBER KENNETH		LOCAL REGISTRATION NUMBER 3201036011290	
1. NAME OF DECEASED - FIRST (Given) KENNETH		2. LAST (Family) CROTEAU	
3. BIRTH STATE/OTHER COUNTRY CT		4. DATE OF BIRTH (month/day/year) 06/16/1953	
5. SOCIAL SECURITY NUMBER [REDACTED]		6. AGE Yrs. 57	
7. EDUCATION - Highest Level Completed BACHELOR		8. MARRIAGE STATUS (at time of death) MARRIED	
9. DECEASED'S RACE - Up to 3 races may be entered (see instructions on back) WHITE, CANADIAN, FRENCH		10. DATE OF DEATH (month/day/year) 12/06/2010	
11. USUAL OCCUPATION - Type of work for most of the year (do not use retired) CHIEF OPERATIONS OFFICER		12. HOURS OF DEATH (month/day/year) 1014	
13. DECEASED'S RESIDENCE (street and number) or location 7245 JENKINS AVE		14. KIND OF BUSINESS (industry or 2, grocery store, road construction, employment agency, etc.) MANUFACTURING	
15. YEARS IN OCCUPATION 15			
16. CITY HESPERIA		17. STATE/OTHER COUNTRY CA	
18. DECEASED'S NAME, RELATIONSHIP W. DEBRA CROTEAU, WIFE		19. DECEASED'S MAILING ADDRESS (street and number, or rural route number, city or town, state and zip) 7245 JENKINS AVE, HESPERIA, CA 92345	
20. NAME OF SURVIVOR (spouse, child, parent) WINNIFRED		21. NAME OF SURVIVOR (spouse, child, parent) ROBERT	
22. NAME OF SURVIVOR (spouse, child, parent) BARBARA		23. NAME OF SURVIVOR (spouse, child, parent) HELEN	
24. PLACE OF DEATH 7245 JENKINS AVE, HESPERIA, CA 92345		25. PLACE OF DEATH (if not at home) SUNSET HILLS MEMORIAL PARK	
26. TYPE OF DEATH CR/BU		27. SIGNATURE OF EMBALMER NOT EMBALMED	
28. NAME OF FUNERAL ESTABLISHMENT SUNSET HILLS MORTUARY INC.		29. SIGNATURE OF LOCAL REGISTRAR MAXWELL OHIKHUARE, MD	
30. PLACE OF DEATH 7245 JENKINS AVE		31. IF HOSPITAL, SPECIFY ONE <input type="checkbox"/> P <input type="checkbox"/> CRP <input type="checkbox"/> DCA <input type="checkbox"/> HOSPITAL	
32. COUNTY SAN BERNARDINO		33. CITY HESPERIA	
34. CAUSE OF DEATH RENAL CELL CARCINOMA		35. TIME OF DEATH (month/day/year) 12/06/2010	
36. IMMEDIATE CAUSE CARDIOPULMONARY ARREST		37. TIME OF DEATH (month/day/year) 12/06/2010	
38. UNDERLYING CAUSE RENAL CELL CARCINOMA		39. TIME OF DEATH (month/day/year) 12/06/2010	
40. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE (CEN 117) NONE		41. TIME OF DEATH (month/day/year) 12/06/2010	
42. SIGNATURE OF PHYSICIAN JOHN R. HAWES D.O.		43. SIGNATURE OF PHYSICIAN HAHN TRINH NGUYEN M.D.	
44. DATE OF DEATH 12/06/2010		45. DATE OF DEATH 12/06/2010	
46. PLACE OF DEATH 7245 JENKINS AVE		47. PLACE OF DEATH 7245 JENKINS AVE	
48. SIGNATURE OF REGISTRAR MAXWELL OHIKHUARE, MD		49. SIGNATURE OF REGISTRAR MAXWELL OHIKHUARE, MD	

CERTIFIED COPY OF VITAL RECORDS

STATE OF CALIFORNIA

COUNTY OF SAN BERNARDINO

DATE ISSUED

Dec 13, 2010

This is a true and exact reproduction of the document officially registered and placed on file in the VITAL RECORDS SECTION, SAN BERNARDINO DEPARTMENT OF PUBLIC HEALTH.

Maxwell Ohikhuare
MAXWELL OHIKHUARE, M.D.
COUNTY HEALTH OFFICER
REGISTRAR OF VITAL STATISTICS



002007868

This copy not valid unless prepared on engraved border displaying seal and signature of Registrar.





COUNTY of SAN BERNARDINO

DEPARTMENT OF PUBLIC HEALTH

351 N. MT. VIEW AVENUE, SAN BERNARDINO, CALIFORNIA 92415-0010

CERTIFICATE OF DEATH

3200936011895

STATE OF CALIFORNIA
USE BLACK INK ONLY NO ERASURES OR ALTERATIONS
VS 1/2/07/01

LOCAL REGISTRATION NUMBER

1. NAME OF DECEDENT - FIRST (Given)		2. MIDDLE		3. LAST (Family)	
MARY				SHOFFSTALL	
4. DATE OF BIRTH mm/dd/yyyy					
03/06/1921					
5. AGE Yrs					
88					
6. SEX					
F					
7. DATE OF DEATH mm/dd/yyyy					
12/26/2009					
8. HOUR (24 Hours)					
1330					
9. BIRTH STATE/FOREIGN COUNTRY		10. SOCIAL SECURITY NUMBER		11. EVER IN U.S. ARMED FORCES?	
CA				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNK	
12. MARITAL STATUS (at Time of Death)		13. DATE OF DEATH mm/dd/yyyy		14. HOURS	
DIVORCED		12/26/2009		1330	
15. EDUCATION - High School Graduate (Last completed grade)		16. WAS DECEDENT HISPANIC/LATINO/SPANISH? (If yes, see instruction on back)		17. DECEDENT'S RACE - Up to 3 races may be listed (see instruction on back)	
HS GRADUATE		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		WHITE	
18. USUAL OCCUPATION - Type of work for most of life. DO NOT USE RETIRED		19. KIND OF BUSINESS OR INDUSTRY (e.g., grocery store, road construction, employment agency, etc.)		20. YEARS IN OCCUPATION	
OWNER OPERATOR		COSMETOLOGY		20	
21. DECEDENT'S RESIDENCE (Street and number or location)					
14043 CHOCO RD					
22. CITY		23. COUNTY/PROVINCE		24. YEARS IN COUNTY	
APPLE VALLEY		SAN BERNARDINO		1	
25. INFORMANT'S NAME, RELATIONSHIP		26. INFORMANT'S MAILING ADDRESS (Street and number or rural route number, city or town, state, ZIP)			
M SHARON ROGONE, DAUGHTER		14043 CHOCO RD, APPLE VALLEY, CA 92307			
27. NAME OF SURVIVING SPOUSE - FIRST		28. MIDDLE		29. LAST (Maiden Name)	
30. NAME OF FATHER - FIRST		31. MIDDLE		32. LAST	
MOSES				DESAOFF	
33. NAME OF MOTHER - FIRST		34. MIDDLE		35. LAST (Maiden)	
TANYA				SHUBIN	
36. BIRTH STATE		37. BIRTH STATE		38. BIRTH STATE	
RUSSIA		RUSSIA		RUSSIA	
39. DISPOSITION DATE mm/dd/yyyy		40. PLACE OF FINAL DISPOSITION			
01/02/2010		ROSE HILLS MEMORIAL PARK 3888 WORKMAN MILL ROAD, WHITTIER, CA 90601			
41. TYPE OF DISPOSITION (S)		42. SIGNATURE OF EMBALMER		43. LICENSE NUMBER	
BU		ASHLEY N FINNIE		9146	
44. NAME OF FUNERAL ESTABLISHMENT		45. LICENSE NUMBER		46. SIGNATURE OF LOCAL REGISTRAR	
ROSE HILLS MORTUARY		FD 970		MAXWELL OHIKHUARE, MD	
47. DATE mm/dd/yyyy		48. DATE mm/dd/yyyy			
12/31/2009					
101. PLACE OF DEATH					
RESIDENCE - HOSPICE					
102. IF HOSPITAL, SPECIFY ONE					
<input type="checkbox"/> P <input type="checkbox"/> ENOP <input type="checkbox"/> DOA <input type="checkbox"/> HOSPICE					
103. IF OTHER THAN HOSPITAL, SPECIFY ONE					
<input type="checkbox"/> Nursing Home, LTC <input checked="" type="checkbox"/> Decedent's Home <input type="checkbox"/> Other					
104. COUNTY					
SAN BERNARDINO					
105. FACILITY ADDRESS OR LOCATION WHERE FOUND (Street and number or location)					
14043 CHOCO RD					
106. CITY					
APPLE VALLEY					
107. CAUSE OF DEATH					
Enter the cause of death - Diseases, injuries, or complications - first 5 words caused death. DO NOT enter immediate events such as cardiac arrest, respiratory arrest, or vascular failure without knowing the etiology. DO NOT ABBREVIATE.					
(A) END STAGE CORONARY ARTERY DISEASE					
(B) YRS					
(C) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
(D) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
(E) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
(F) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
(G) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
108. BODILY PERFORMED?					
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
109. AUTOPSY PERFORMED?					
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
110. USED IN DETERMINING CAUSE?					
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
111. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN 107					
NONE					
112. WAS OPERATION PERFORMED FOR ANY CONDITION BY ITEM 107 OR 111? (If yes, list type of condition and date)					
NO					
113. IF FEMALE, PREGNANT IN LAST YEAR?					
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNK					
114. I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FROM THE CAUSES STATED					
115. SIGNATURE AND TITLE OF CERTIFIER					
ASHISH MALHOTRA M.D.					
116. TYPE ATTENDING PHYSICIAN'S NAME, MAILING ADDRESS, ZIP CODE					
JOHN R HAWES JR D.O.					
117. DATE mm/dd/yyyy					
12/30/2009					
118. I CERTIFY THAT MY OPINION DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FROM THE CAUSES STATED					
119. TYPE ATTENDING PHYSICIAN'S NAME, MAILING ADDRESS, ZIP CODE					
JOHN R HAWES JR D.O.					
120. DATE mm/dd/yyyy					
12/30/2009					
121. INJURED AT WORK?					
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNK					
122. INJURY DATE mm/dd/yyyy					
123. HOUR (24 Hours)					
124. PLACE OF INJURY (e.g., home, construction site, wooded area, etc.)					
125. DESCRIBE HOW INJURY OCCURRED (Events which resulted in injury)					
126. LOCATION OF INJURY (Street and number, or location, and city, and ZIP)					
127. SIGNATURE OF CORONER / DEPUTY CORONER					
128. DATE mm/dd/yyyy					
129. TYPE NAME, TITLE OF CORONER / DEPUTY CORONER					
130. STATE REGISTER					
A B C D E					
FAX AUTH. #					
CENSUS TRACT					

CERTIFIED COPY OF VITAL RECORDS

STATE OF CALIFORNIA

COUNTY OF SAN BERNARDINO

DATE ISSUED

Jan 5, 2010

This is a true and exact reproduction of the document officially registered and placed on file in the VITAL RECORDS SECTION, SAN BERNARDINO DEPARTMENT OF PUBLIC HEALTH.

Margaret M Beed MO

MARGARET BEED, M.D.
COUNTY HEALTH OFFICER
REGISTRAR OF VITAL STATISTICS

This copy not valid unless prepared on engraved border displaying seal and signature of Registrar.



001921193

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE